HOSPITAL SERVICES: NEEDS AND COSTS*

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I HAVE known of the New York Academy of Medicine for years. However, I seldom traveled east of the Mississippi until I was elected to Congress, so it is a special pleasure to be with this audience. I cannot help but surmise that this program perhaps was put together like many programs, in which it is felt that there should be an important speaker from government. And perhaps your chairman wrote, as I understood someone did a few years ago, to one of the congressional committees in Washington and said, we should like a speaker, it is a very important meeting. We are going to have a large number of people, we should like nothing lower than a Congressman, and of course the answer came back, there is nothing lower than a Congressman.

However, I do think daily about our health care problems, and other problems in this election year. The thing that has really received the attention of Congress, of the people of the country, and of many special groups, is the spiraling costs of health care. Organized medicine is also concerned about this, and so we have this panel called "Hospital Services, Needs, and Costs."

It is perhaps unnecessary to cite all the facts about the costs of health care to a sophisticated audience but I shall review them, at least in part. The first problem with our health care system is spiraling costs. We are told that the cost per capita of health care in 1950 was $79 per person, and that it is now $358 per person per year. We are often reminded that the percentage of the gross national product spent for health care was 5.3% in 1960 and has risen to 7.5% in 1971.

With specific reference to hospitals: there has been an increase of 30% in hospital costs from a 1959 base, rising eight times as rapidly

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as other services and goods in an inflationary economy. We are all aware of the important health legislation passed in 1965, Titles 18 and 19 of the Social Security Act: Medicare and Medicaid.

In 1965 it was predicted that we would spend $2.9 billion in fiscal year 1971 on Medicare, but instead we spent $5.5 billion. The costs of Medicaid have increased from $1.3 billion, when it began, to $6.8 billion in fiscal year 1972. So we can see at least partly that these spiraling costs are very real and very great.

Spiraling costs have had two results: one result is that it has priced the consumer out of the health care market. So we see increasing pressure for government to pay all or part of people's medical bills. The old people were the first group to exhaust the traditional means of financing health care: that is, out-of-pocket payments, health insurance for those who can afford it, contributions, philanthropy (often on the part of the providers), and state-government contributions.

But now other people have also exhausted these traditional means of buying health care. We see, therefore, an insistence upon additional federal or state government aid for the payment of health care. We can understand the insistence upon additional federal or state government aid for the payment of health care. And we can understand the insistence for federal and state aid clearly when we realize that a family of four today has health care costs in excess of $1,400, while the median income in our nation for a family is about $9,800.

Thus we are talking about 15% of people's earnings going for health care. There has been a second result of spiraling costs—a very important result—the drive for containment of health cost. There is a great urgency for everyone to do something about the rate of inflation in health care. As a result we have reached for solutions, and we are beginning to perceive a pattern in national health insurance or in some sort of universal payment mechanism. There is some risk in predicting what form this ultimately might take, but it is worth considering.

We shall probably have an expansion of Medicare to cover health costs that Medicare does not presently cover. The average person over 65 is paying almost $300 out of pocket on his or her total health bill, which now exceeds $900 per year. The average person over 65 is beginning or approaching the point of paying as many out-of-pocket dollars as he was paying prior to Medicare. We may well see an expansion of Medicare.

We are likely to see a federalization of Medicaid. State-federal programs somehow have not worked well. Kerr-Mills did not work well at all. Even today there are two states without Medicaid. These are states with many brown people: Arizona and Alaska, where residents somehow think that the Bureau of Indian Affairs is going to take care of the Indian population and where the bureau does not take care of the Indian.

Medicaid has another aspect to be considered: the states are presently paying about $3.2 billion in Medicaid costs. If the federal government picked up this bill, this would be one form of federal revenue sharing. We can also anticipate some type of payment mechanism for the huge bulk of the American people who do not qualify for Medicare or who are not medically indigent. It seems that the pattern is likely to be a national health insurance standards act. This will involve mandating that our people have a certain type of health insurance, perhaps through an employer-employee arrangement with a provision whereby people who are unemployed for six months will still continue to be insured.

The fourth item that may or may not be necessary but which is perhaps politically the most popular, is catastrophe health insurance. There are 49 million families in this country, and it is said that one million families, or one out of 49 families in this country, has a medical bill each year which is catastrophic for that family, which exhausts their insurance and exhausts almost all their financial resources.

All these things obviously have meaning for the hospital, and I attempt to touch lightly upon the meaning of our health care problems for the hospital. One consequence is that we may see a requirement of a certificate of need for treatment for inpatients that is likely to be prospective and continuous. In order to obtain a certificate of need, the patient will have to pass a certain threshold before he enters the hospital and, if the care continues, the patient will have to be recertified as in need of continuing hospital inpatient care.

We are also likely to see retrospective examination of the patient's care as an outpatient. Was this care necessary? This goes to the question of quality which we shall discuss shortly. Then, of course, we shall see a great deal of review of utilization.

Another eventuality is prospective budgeting. You may be aware of the fact that Senator Edward M. Kennedy's Health Security Act

contains prospective budgeting for hospitals. We now look for solutions to the spiraling costs—the cost-containment factor.

We expect the Health Maintenance Organization (HMO) to be a possible mechanism for containing costs. We have studied the prototype HMOs and found that they appear to be able to contain costs. There are several reasons that they have this potential, but first we need to establish a definition of HMO. An HMO is an organized system of health care delivery whereby an enrolled population is provided relatively comprehensive health care benefits, a standard package of benefits, on a prepaid basis. An HMO thereby must have the ability to deliver comprehensive health care.

As we examine the prototypes which presently take care of about 6.5 million people, and of which there are perhaps 30, the HMO appears to be an approved mechanism, although the American Medical Association (AMA) is saying the HMO is experimental. I agree with the AMA that government assistance to HMOs is experimental, but the concept in itself is not experimental, and we find that there are incentives within HMOs to hold costs down.

An HMO generally will use about two hospital beds per 1,000 enrollees, while in our population as a whole we find about four hospital beds per 1,000 enrollees. An HMO is more likely, because of the fact that it has been paid prospectively, to use appropriate facilities and appropriate personnel for the care of people.

There are other incentives. HMOs are more likely to have at least the potential for using paramedical personnel in a better way. The use of paramedical personnel should have a great impact in the hospital because we have problems in each state with the certification or licensing of paramedical personnel, great medical legal problems within the hospital, and the problems of staff relations within the hospital which must be solved.

We shall find within the HMO an incentive to spend money for money-saving technology. Within our hospitals or at least too often within our present hospitals we find that when the hospital has money it adds another service. This new service may indeed be expensive and it may be underutilized; it may be a service which is available close by, and this has resulted in spiraling costs.

So we are approaching the HMO solution for cost containment. Generally speaking, progressive care will help contain costs. Progres-

sive care does not require an HMO. We shall examine very carefully our health insurance policies in this nation and determine whether it would not perhaps be wise to mandate certain types of coverage within every indemnity health insurance policy, so we can achieve what I refer to as progressive care. We should take care of the patient with the appropriate personnel and facilities, so that he will not unnecessarily move into the expensive hospital for acute care when he could go to a more modest facility. This is another thing which we must study.

The second problem in our health care delivery system is the lack of availability, accessibility, and continuity of care. This is probably best measured by the number of doctors per 100,000 people. There are about 150 doctors per 100,000 people in our country, but we also know that health care is likely to be much less available in many geographic areas of our nation than in others. We know that New York as a state has three times as many physicians per 100,000 as the state of Mississippi, and about twice the number of doctors per 100,000 people as my home state of Kansas.

We in Congress have addressed this problem to some degree by the Health Manpower Training Act, in which we linked an increase in professional school enrollment with capitation and institution grants from the federal government. This was a lesson for me in legislation because I had thought that we were writing a great bill which would solve all problems. And then we saw the president's request for fiscal year 1973. We find that he would like to have 37% of the authorization appropriated, and we realize that with 37% of the authorization we are not likely to increase the number of professional personnel available to the people of the country.

We know that Congress is going to increase this amount. In fact, the figure being mentioned is about 65%, but we also know that the presidential recommendation was $100 million less than the amount of money spent for health manpower in fiscal year 1972. So you can understand the problem we have. I can sympathize with people's impatience with rhetoric. We see in the president's State of the Union Message the statement that there had been two great health acts: the Cancer Act and the Health Manpower Training Act. And then we notice that, as these programs are filtered through the Office of Management and Budget, somehow money is not made available for them.

Another manpower problem is the lack of primary physicians. Primary physicians are variously defined, but we all know these include the family physician, the general internist, the pediatrician, the obstetrician, and the gynecologist, at least in the setting in which I practice. We find that only about 30 to 35% of our doctors presently fall in those categories, and as we look at some of the HMO prototypes which work especially well—for example, the Group Health at Puget Sound—we find that they may have 60 or 65 or 70% of their physicians in these categories. Only by doubling the number of physicians will we have enough primary physicians to take care of people on a one-to-one basis.

Access to health care is something else. We know that there are institutions, for example, in New York City, with large numbers of people living nearby who cannot receive their care from those institutions.

One thing at present which stands in the way of providing medical care is the mechanism of payment. Some people have no means of paying for health care. Also there are language barriers, and barriers of culture. These are not easy problems with which to deal. A lack of accessibility to other health care personnel has resulted in the flooding of our emergency rooms and a shortage of primary physicians.

There is also the problem of continuity of care, also not easily solved. We realize that our care indeed may be episodic, that we may see a patient for an illness, and that a patient indeed may not be seen for a number of years by any other health professionals. So we look for solutions. We find again that the HMO system is attractive because it is organized, it has a defined population, it should at least be able to plan for the availability, accessibility, and continuity of care for a defined population.

We also believe that only if there is an adequate payment mechanism can we reach into the underserved areas. In other words an HMO cannot exist without income. There is no way for private physicians to exist if people cannot pay. So the payment mechanism is important.

We often speak of the continuity of care. The HMO has some attractions in this connection. A unit record is a must within an HMO. This at least addresses itself to continuity of care. Also, the recently developed problem-oriented record perhaps would provide answers within HMOs or similar institutions.

The third issue is quality control. The quality of American medicine at its best is said to be—and I don't think anybody argues with this—the best in the world. But sometimes this is not true. When peer reviews have been made, physicians have been confronted with the fact that there is much poor quality medicine being practiced in this country. This problem must be solved, or we must at least attempt to solve it. There are many reasons for this unsatisfactory situation, such as the failure to have graduate study or continued education, and the factor of overwork. But as we look at the increasing number of government dollars going into medical care we realize that the government could insist not only on cost containment but on quality, and when we look at that process we wonder how it can be done.

Peer review, the ongoing assessment of quality care, is probably the only acceptable approach right now. It is possible that the state of the art has reached only this point and this is all we can do now. This review probably should be implemented by peers, but the government can say: Since the government makes a financial contribution you come forth with a plan, tell us how you are going to implement it, and we shall check up once in a while to make sure you are carrying it out properly.

This is what we are most likely to see. We, of course, have heard of the professional-standards-review organization, and this has great implications for hospitals. Is the quality of care in the hospital to be judged by a committee from the local medical society? And what are the implications of this for an HMO? The HMO may not be the best way of delivering medicine: in fact, I anticipate that it will not be the majority way or probably the favorite way of delivering medical care for some time to come.

Do we want the HMO to be at the mercy of the local medical society in assessment of quality? These are real questions. We should all like to see an assessment of outcome at some time. We should like to be able to ask: If 1,000 men have coronaries between the age of 50 and 55, how many should be alive at the end of six months, a year, and five years? How does your organization, your method of delivering care, compare with other methods of delivering care?

Comprehensive health planning is extremely important, but it has not worked very well. We have many weak 314-B organizations. In fact, comprehensive health planning presently still is in the process of

development, and we must ask whether it will ever come into being.

The federal government may well say that unless it approves the purchase of $100,000 in equipment, it will discontinue payment to an institution. This, of course, would be an effective way of controlling expenditures. One of the great abuses in this situation I see again and again in the rural areas of Kansas. We have hospitals built where there are no doctors and no health personnel. We also have one or two doctors much overworked in a small community, and the easiest thing for them to do is to hospitalize every patient who comes in from more than 20 miles away for perhaps one, two, or three days, because that is the easiest way to care for them.

We see this kind of abuse continuously, resulting of course from the plan of putting hospitals in small communities—a plan which has failed because we have no way of getting personnel into small communities. There is much talk about franchising hospitals. There is much talk about local planning versus state planning versus federal planning. Such discussions all have implications for the hospital.

Another topic which has strong implications is the so-called supercenter. Dr. Michael DeBakey was before our committee when we were talking about diseases of the heart, lung, and blood vessels. Dr. DeBakey said, "I think we need an awful lot more Baylor-M.D., Anderson type of institutions." I am very much inclined to agree with him. But we probably are going to see an increased number of so-called tertiary care facilities, perhaps specializing in only one field of health care.

As a result of this, hospitals increasingly will become secondary-care units where we provide the garden variety of care. But for the more expensive and difficult treatment of advanced or life-threatening malignancies we may well see patients going into tertiary-care facilities.

The third item in this potpourri is the matter of manpower education of health personnel. This has been paid for, again, by the patient. This is not a satisfactory arrangement, and we all know that as more and more government money goes into education, the government is not going to spend money for services that are then syphoned off for education.

We recently held hearings for several weeks on health manpower, but I have no idea whether it costs $7,000 or $27,000 a year to educate a medical student. But eventually we are going to obtain this information, and then the public is going to say: we have no objection to pay-

ing for health education, but we are going to require that we get the type of health personnel that we need, in other words, the primary physician.

We may well see the day when money will be available to train pediatricians, general internists, and primary physicians of various kinds, but no money to train increasing numbers of sophisticated surgeons or endocrinologists.

How education is financed is of great importance to the hospital and, as I said, we are going to pay for it with public money. There will be probably additional demands upon the hospital. I have given you a peak-to-peak review of the things that I consider important to the hospital, including not only needs and costs, but also such factors as the medical staff, the hospital itself, and paramedical personnel: full-time and attending staff.